Patient Nursing and Caregiver Form

(To be submitted by Class Member in support of NICA Class Action Claim)

Patient Name: ____________________ **Date of Birth:**________________

The amount and level of professional care recommended and described below is/was medically necessary for the dates indicated below:

(Please choose the most appropriate level of caregiver)

- **CNA, EMT, OTA or PERSONAL CARE AIDE:** Please indicate which apply and provide additional information if needed.

__Feeding by mouth____
__Diapering____
__Dressing____
__Bathing____
__Turning____
__Lifting____
__Safety supervision____
__Other (explain)____
____

 # CNA/EMT/OTA/PCA hours per day ______ or week _____ Duration (date) ______________________
____

OR

- **LPN:** Please indicate which apply and provide additional info where requested.

__Ventilator (type) continuous or intermittent ____________________________
__Trach care — frequency of dsg changes and care ______________________
__CPAP, BIPAP
__G-tube continuously or how
frequently____
__Oxygen continuous, unstable
__Suctioning frequency _______________________________________
__Medication (simple, moderate, complex) number & route __________________
__Intermittent Cath (frequency) _________________________________
__Wound care -- frequency of dsg changes and care _________________________
__Number of hospitalizations in past year ____________________________
__Special treatments (please specify) ______________________________
__Seizures – how often________________ severity______________________

 # LPN hours per day ______ or week _____ Duration (date) ______________________
____

OR

- **RN:** Please indicate which apply and provide additional info where requested.

__Receives IV medications
__Receives blood or blood products
__Requires Continuous ventilation
__Requires frequent medication adjustment due to condition changes
__CPAP, BIPAP
__G-tube continuously or how frequently
____
__Oxygen continuous, unstable
__Suctioning frequency ____________________________
__Medication (simple, moderate, complex) number & route____________
__Intermittent Cath (frequency) ____________ ______________
__Wound care -- frequency of dsg changes and care ______________
__Trach care — frequency of dsg changes and care ______________
__Number of hospitalizations in past year ______________________
__Special treatments (please specify) ________________________
__Seizures – how often________ severity_____________________
__Other reasons ____

 # RN hours per day _____ or week _______ Duration (date) ____________________
____

- **COMMENTS:** (Please use an additional sheet if more space is needed)

Physician certifies ____________________________ is capable of providing
(Parent)

the professional care described above: Yes __NO__

I affirm, under penalty of perjury, that this form does not contain any false, incomplete or misleading information, that I have not omitted or concealed any material information. I understand this information is being submitted to support payment for care paid by NICA under Statute 766.301-766.316, F.S., and I understand that NICA is materially and substantially relying upon this affirmation in processing requests for payment.

Physician Name: ______________________________License #_____________________

Signature__________________________________ Date_________

Contact Phone: ___________________ Fax: ________________

Please return to: NICA, P. O. Box 14567, Tallahassee, Florida 32317-4567
Phone: (850) 488-8191 Fax: (850) 922-5369